STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK CONVALESCENT AND REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/14/18 through 08/16/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/14/2018 through 08/16/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 80 certified bed facility was 66 at the time of the survey. The survey sample consisted of 30 resident reviews.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		8/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/29/2018

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F 640	Continued From page 1 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the provider failed to transmit(within 14 days of death) a Death in Facility tracking form for 1 of 30 surveyed residents.	F 640	1.The Death in Facility record for resident #1 was transmitted on August 13, 2018. 2.The Director of Nursing/Designee has reviewed all deaths in the facility over the	

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F 640	Continued From page 2 Resident #1 was admitted for hospice services on 6/26/2017. Her diagnoses included: Cerebral Palsy, adult failure to thrive, hemiplegia, and hydrocephalus. Resident #1 expired on 4/23/2018. A Death in Facility tracking form with a discharge date (Minimum Data Set field A2000) of 4/23/2018 should have been transmitted by 5/7/2018. Facility staff transmitted the Death in Facility record on 8/13/2018. The Resident Assessment Instrument (RAI) Manual (which lists requirements for the Minimum Data Set), on page 2-36, states: Death in Facility Tracking Record (A0310F=12) · Must be completed when the resident dies in the facility or when on LOA. · Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days). · Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days). · Consists of demographic and administrative items. · May not be combined with any type of assessment. On 8/16/2018 at 12:15PM, an interview was conducted with RN B, the facility Minimum Data Set coordinator. When asked if the Death in Facility record was transmitted timely, she replied "No." No further information was provided prior to exit.	F 640	last 90 days to ensure the Death in Facility record was completed and transmitted within 14 days of the death. If any discrepancies found, corrective action will be taken in compliance with RAI manual guidelines. 3.The facility MDS team members have been reeducated regarding completion and transmittal of Death in Facility record. The in-service will include but is not limited to a review of the Resident Assessment Instrument (RAI) guidelines for completion and transmittal requirements of Death in Facility record as well as use of the missed assessment report. 4.The Director of Nursing/Designee will audit 100% of discharged resident records weekly for six weeks to ensure the Death in Facility record has been completed and transmitted within 14 days of death if indicated. The Director of Nursing/Designee will review finding and report any trends noted to the QAA committee at least quarterly.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		8/31/18

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F 645	Continued From page 3 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645		

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F 645	Continued From page 4 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility record review, the facility failed to ensure a PASARR screening was conducted on or prior to admission to facility for 1 Resident (Resident # 22) in a survey sample of 30 Residents. The findings include Resident #22 was a 75 year old woman admitted to the facility on 7/23/2012 with diagnoses of but	F 645	1.The PASARR screening for Resident #22 was completed on August 15, 2018 when unable to locate original PASARR screening form completed on admission. 2.The Administrator/Designee will conduct a medical record review of current residents to ensure a PASARR screening has been conducted on or prior to admission. Any discrepancies noted will	

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F 645	Continued From page 5 not limited to DVT (deep vein thrombosis) Schizophrenia, Anxiety disorder, Bipolar disorder and Major depressive disorder. Her latest (Minimum Data Set) MDS (a screening tool) was a quarterly with an (Assessment Reference Date) ARD of 06/14/2018 coded resident as having a (Brief Interview of Mental Status) BIMS score of 5 indicating severe cognitive impairment. On 8/14/18 at 9:20 AM, a record review was conducted and found that Resident #22 did not have a PASARR completed prior to or on admission. On 8/15/18 at 4:30 PM, this surveyor requested copy of PASARR from the DON and was told " I will have that document in the morning when you arrive." On 8/16/18 at 10:00 AM, the Assistant Administrator (Employee D) stated " We are looking for the document. Resident #22 has been here since 2008 and has had a few admissions and discharges so we are trying to locate the original PASARR." On 8/16/18 at 11:30 AM, the Assistant Administrator (Employee D) brought in PASARR Level 1 document dated 8/16/2018. The Assistant Administrator (Employee D) stated " We could not locate the original PASARR so we have filled out a new one." Administration was aware of documentation and no further information was provided.	F 645	be corrected. 3.The Administrator will educate the Assistant Administrator/Admissions coordinator on PASAAR Screening. The inservice includes but is not limited to a review of the PASARR screening tool and the importance of ensuring the PASAAR screening has been completed on or prior to admission to the facility. 4.The Administrator/Designee will review 100% of resident admissions weekly for six weeks to ensure the PASARR screening is completed on or prior to the residents'□ admission to the facility. Any trends or patterns will be reported to the QAA committee on at least a quarterly basis.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		8/31/18

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F 656	Continued From page 6 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 7 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the provider failed to develop a comprehensive care plan for 1 of 30 sampled residents (Resident #4). Findings: Resident #4 was admitted 10/9/2017 with diagnoses that include: cerebral vascular accident with dysphagia, muscle weakness, and muscle weakness. Her most recent Minimum Data Set(MDS) assessment was a quarterly assessment dated 510/2018, which showed that Resident #4 was moderately cognitively impaired and required assistance of 2 staff members for bed mobility and transfers, and assistance of 1 staff member for eating and dressing. Review of the medical record showed: A clinical note dated 5/31/2018 stating "Podiatry in to see resident an concerned with infection of right foot second toe, callous noted under second toe and MD shaved it down and drainage noted. Pa made aware new orderes [sic] received and resident representative has been notified." A clinical noted dated 6/1/2018 stating "PA given X-ray results, right foot second toe assessed, small open area from where podiatry has shaved down callous, wound care protocol initiated." A clinical noted dated 6/27/2018 stating "Right foot second toe dry and scabbed no TX needed at this time. PA and resident representative are aware."	F 656	1.The comprehensive care plan for resident #4 was updated on 08/16/18 to include right foot 2nd toe and risk for recurrent skin issues. 2.The care plans of residents with skin issues will be reviewed to ensure areas of concern are addressed in the comprehensive care plan with appropriate interventions in place. The Assistance Director of Nursing/Designee will be responsible for ensuring resident care plans are updated as needed to reflect individual needs and conditions. 3.RNs/LPNs will be reeducated on Updating Resident Care Plans. The in-service will include but is not limited to a review of facility policy on care plans and the importance of ensuring they are updated timely as necessary to reflect current needs and diagnoses. 4.The Director of Nursing / Designee will review the care plan of 20% of residents with skin issues weekly for six weeks to ensure the care plan has been updated to reflect the individual needs and conditions of the resident. The Director of Nursing will review findings with the Quality Assurance Assessment Committee at least quarterly.	

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F 656	Continued From page 8 A clinical note dated 7/24/2018 stating "Area to right foot second toe reopened when resident was getting feet washed when in the shower. Wound care protocol initiated and resident representative made aware." The June 2018 Treatment record shows treatments to Resident #4's right second toe from 6/2/2018 through 6/27/2018. The July 2018 Treatment record shows treatments to Resident #4's right second toe from 7/24/2018 through 7/31/2018. The August 2018 Treatment record shows treatments to Resident #4's right second toe from 8/1/2018 through 8/15/2018. A review of the resident's care plan showed interventions and goals for skin in general, but not specifically for the right second toe. Observation of Resident #4's right second toe on 8/15/2018 at 11:30AM showed intact skin. An interview was held on 8/16/2018 at 8:00AM with Administrator C and RN B. The medical record was reviewed. Administrator C and RN B were asked if the resident's recurrent skin issues for her right second toe had been addressed in the care plan, and both staff members replied "No." When asked if the skin issue should have been addressed on the care plan, Administrator C replied "Yes." No further information was provided prior to exit.	F 656		
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		8/31/18

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F 695 SS=E	Continued From page 9 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility failed to provide oxygen therapy consistent with infection control measures for 3 Residents (Resident # 16 #18 and #50) in a survey sample of 30 Residents. 1. For resident # 16, the facility failed to date oxygen and nebulizer tubing. 2. For Resident #18, the facility failed to date oxygen and nebulizer tubing. 3. For Resident #50, the facility failed to label and date oxygen tubing. The findings included: 1. For Resident # 16, the facility failed to date oxygen and nebulizer tubing. Resident # 16 was a 74 year old female admitted to the facility on 09/20/2016 with diagnoses of but not limited to COPD (Chronic Obstructive Pulmonary Disease) Dementia, Bipolar Disorder, and Anxiety disorder.	F 695	1.The oxygen and nebulizer tubing for Residents #16, #18 and #50 was immediately changed, labeled and dated on August 15, 2018. Facility RNs/LPNs were immediately notified of the change in policy regarding dating oxygen/nebulizer tubing. 2.The Director of Nursing/Designee did a 100% audit of all residents who receive oxygen/nebulizer treatments and immediately changed, labeled and dated all tubing. The facility policy on Oxygen Administration and Safety Guidelines was revised and updated to reflect the expectation of dating tubing prior to use. 3.RNs/LPNs will be reeducated on Oxygen and nebulizer tubing use. The inservice will include but is not limited to a review of the newly revised policy on Oxygen Administration and Safety	

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F 695	Continued From page 10 Most recent (Minimum Data Set) MDS was a quarterly with an (Assessment Reference Date) ARD of 5/31/2018 coded Resident as having a (Brief Interview of Mental Status) BIMS score of 4 indicating Severe Cognitive Impairment. On 8/14/2018 during initial tour of facility at 6:40 AM, the resident was noted to be receiving oxygen and neither tubing the nor the mask were dated. There was a Nebulizer with Resident 16's name on it sitting on the table next to her bed. This tubing had also not been dated. During the debriefing with Administrative staff on 8/15/2018 at 1:30 PM, the Assistant Administrator, Director of Nursing, and Corporate Nursing Consultants (Employee C and Employee F) were informed of the findings. The Corporate Consultants stated the facility's policy was to document the date the tubing was changed on the Treatment Administration Records but not to label the oxygen tubing. The Corporate Consultants (Employee C and Employee F) and the Director of Nursing stated the facility would rectify the problem immediately. The Corporate Nurse Consultant (Employee C) presented a copy of the facility policy on "Oxygen Administration and Safety Guidelines, Revised 1/30/2018" Review of the document revealed statements on page 2 of 2 : "Documentation Guidelines: Treatment Administration Record Other Documentation May Include: Date, time,	F 695	Guidelines to include the importance of dating oxygen and nebulizer tubing prior to use. 4.The Director of Nursing/designee will audit 20% of residents with orders for oxygen and nebulizer treatments to ensure proper dating of tubing weekly for six weeks. Any trends or patterns will be reported to the Quality Assurance Committee on at least a quarterly basis.	

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F 695	Continued From page 11	F 695		

method of administration and liter flow as ordered."

When asked about the documentation, the Corporate nurse consultant reiterated that the facility documented on the TAR, not on the tubing itself.

On 8/16/2018 at 8:15 AM, this surveyor observed the oxygen tubing was dated.

On 8/16/2018 at 12: 15 PM during the end of day debriefing, the facility Administrative staff stated the oxygen tubing for all residents receiving oxygen had been changed on 8/15/2018 and dated/ labeled.

No further information was provided.

2. For Resident #18, the facility failed to date oxygen and nebulizer tubing.

Reside# 18 was an 87 year old female admitted to the facility on 04/12/2018 with diagnoses of but not limited to reduced mobility, weakness, left knee replacement, fatigue, and unsteadiness on feet. Her most recent (Minimum Data Set) MDS with an (Assessment Reference Date) ARD of 6/13/2018 coded her has having a (Brief Interview of Mental Status) BIMS Score of 15 indicating no cognitive impairment.

On 8/14/2018 during initial tour of facility at 6:45 AM resident was noted to be receiving oxygen and neither tubing the nor the mask were dated.

Resident #18 also had a nebulizer with tubing

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	495342	A. BUILDING _____ B. WING _____	08/16/2018

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F 695	Continued From page 12	F 695		

connected to it sitting on the bedside table and the tubing was not dated .

On 8/14/2018 a review of clinical record found Resident #18 was diagnosed with pneumonia on 8/6/2018 via chest x-ray and started on antibiotics, Oxygen and Nebulizer treatments

During the debriefing with Administrative staff on 8/15/2018 at 1:30 PM, the Assistant Administrator, Director of Nursing, and Corporate Nursing Consultants (Employee C and Employee F) were informed of the findings.

The Corporate Consultants stated the facility's policy was to document the date the tubing was changed on the Treatment Administration Records but not to label the oxygen tubing.

The Corporate Consultants (Employee C and Employee) and the Director of Nursing stated the facility would rectify the problem immediately.

The Corporate Nurse Consultant (Employee C) presented a copy of the facility policy on "Oxygen Administration and Safety Guidelines, Revised 1/30/2018" Review of the document revealed statements on page 2 of 2 :

"Documentation Guidelines: Treatment Administration Record

Other Documentation May Include: Date, time, method of administration and liter flow as ordered."

When asked about the documentation, the Corporate nurse consultant reiterated that the facility documented on the TAR, not on the tubing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK CONVALESCENT AND REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 13	F 695		

itself.

On 8/16/2018 at 8:15 AM, the surveyor observed the oxygen tubing was dated.

On 8/16/2018 at 12: 15 PM during the end of day debriefing, the facility Administrative staff stated the oxygen tubing for all residents receiving oxygen had been changed on 8/15/2018 and dated/ labeled.

No further information was provided.

3. For Resident # 50, the facility staff failed to label and date the oxygen tubing.

Resident # 50 was an 85-year-old female who was admitted to the facility on 11/11/2013 with diagnoses of but not limited to: Sarcoidosis, Atrial Fibrillation, Pneumonia, Bronchitis, Dysphagia, Edema, Pulmonary Embolism and Hypertension.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/11/2017. The MDS coded Resident # 50 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of 1 staff person with Activities of Daily Living. Resident # 50 was coded as frequently incontinent of bowel and bladder.

During initial tour on 8/14/2018 at 6:50 AM, Resident # 50 was observed with oxygen via nasal cannula at 2 liters per minute. There was no date noted on the tubing.

On 8/15/2018 at 8:45 AM, there was no date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	08/16/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 14 noted on the oxygen tubing. On 8/15/2018 at 8:55 AM, an interview was conducted with nurse LPN (Licensed Practical Nurse) A, who stated the facility did not place dates on tubing. LPN A stated the facility changed the tubing weekly and documented the date changed on the Treatment Administration Records(TAR) for each resident receiving oxygen. On 8/15/2018 at 9:11 AM, LPN A presented a copy of the August 2018 Treatment Administration Record which revealed an order for "Oxygen: Change oxygen cannula/mask and tubing weekly when in use. Every one week. Starting 5/23/2017." There was documentation of signatures on 8/7/2018 and 8/14/2018. During the debriefing with Administrative staff on 8/15/2018 at 1:30 PM, the Assistant Administrator, Director of Nursing, and Corporate Nursing Consultants (Employee C and Employee F) were informed of the findings. The Corporate Consultants stated the facility's policy was to document the date the tubing was changed on the Treatment Administration Records but not to label the oxygen tubing. The Corporate Consultants (Employee C and Employee F) and the Director of Nursing stated the facility would rectify the problem immediately. The Corporate Nurse Consultant (Employee C) presented a copy of the facility policy on "Oxygen Administration and Safety Guidelines, Revised 1/30/2018" Review of the document revealed statements on page 2 of 2 : "Documentation Guidelines: Treatment Administration Record	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 15 Other Documentation May Include: Date, time, method of administration and liter flow as ordered." When asked about the documentation, the Corporate nurse consultant reiterated that the facility documented on the TAR, not on the tubing itself. On 8/16/2018 at 8:15 AM, the oxygen tubing was observed to be dated. On 8/16/2018 at 12: 15 PM during the end of day debriefing, the facility Administrative staff stated the oxygen tubing for all residents receiving oxygen had been changed on 8/15/2018 and dated/ labeled. No further information was provided.	F 695		